

1330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City c. LENGTH OF STAY IN 1b 42 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS 8 .6th e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthony Paulus Archer		4. DATE OF DEATH Month January Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.	11. IF UNDER 24 HRS. Months 62 Days 62 Hours 62 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper		10b. KIND OF BUSINESS OR INDUSTRY Barrels	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel H. Archer	
14. MOTHER'S MAIDEN NAME Emma Purnell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) W.W.1 Army	
16. SOCIAL SECURITY NO. 217-12-9608		17. INFORMANT James Archer	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 hr 9 mths 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/17/59 , to 1/17/59 , that I last saw the deceased alive on 1/17/59 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Cecil A. Duverney		ADDRESS (Street, city or town, state) 801-4th St, Pocomoke, Md.	
PHYSICIAN'S NAME (Type) CECIL A. DUVERNEY		DATE SIGNED 1/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/20/59	22c. NAME OF CEMETERY OR CREMATORY Home Benf. Cem.	22d. LOCATION (City, town, or county) (State) Stockton, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, W		24a. REC'D BY REGISTRAR DATE JAN 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 11

1911

1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Age at death: _____

6. Sex: _____

7. Occupation: _____

8. Marital status: _____

9. Education: _____

10. Religion: _____

11. Date of birth: _____

12. Date of death: _____

13. Date of death: _____

14. Date of death: _____

15. Date of death: _____

16. Date of death: _____

17. Date of death: _____

18. Date of death: _____

1332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b 60 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N. MAIN ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUBY Middle B Last BRADFORD		4. DATE OF DEATH Month JAN. Day 22 Year 1959		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 6, 1884		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEWARK, MD.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES BUTLER		14. MOTHER'S MAIDEN NAME CHARLOTTE HOLLAND		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT MISS BRENDA BRADFORD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 22 Jan 1959 to 23 Jan 1959 , that I last saw the deceased alive on 22 Jan 1959 , and that death occurred at 11:15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ocean City, Md DATE SIGNED 24 Jan 59 ACTUAL SIGNATURE J. R. Thomas PHYSICIAN'S NAME (Type) J. R. Thomas ADDRESS Ocean City, Md													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/24/59		22c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES		22d. LOCATION (City, town, or county) (State) NEWARK MD		23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage		24a. REC'D BY REGISTRAR DATE JAN 27 '59		24b. REGISTRAR'S SIGNATURE James A. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

103340

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

NO. 103340

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		10/15/1900		Male		White		Married		Farmer		Heart Disease		Home		10/20/1950		J. Smith		A. Jones	
Date of Death		Place of Birth		Age at Death		Color		Religion		Education		Duration of Illness		Nature of Illness		Time of Day		Signature of Informant		Signature of Registrar	
10/20/1950		Maryland		50		White		Catholic		High School		2 Weeks		Heart Failure		10:00 AM		B. Brown		A. Jones	
Date of Burial		Place of Burial		Age at Burial		Color		Religion		Education		Duration of Illness		Nature of Illness		Time of Day		Signature of Informant		Signature of Registrar	
10/25/1950		Catholic Cemetery		50		White		Catholic		High School		2 Weeks		Heart Failure		10:00 AM		B. Brown		A. Jones	

103340

1333

CERTIFICATE OF DEATH

01331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Berlin Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>H.</u> Last <u>Crippen</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Embrose Crippen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>215-36-1567</u>	
17. INFORMANT <u>Hellen Crippen</u>		Address <u>Berlin Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>Vagus</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-20</u> , 19 <u>59</u> to <u>1-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-25</u> , 19 <u>59</u> , and that death occurred at <u>12:50</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ivory U. Seely, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Seely, Jr.</u>		DATE SIGNED <u>1-28-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		ADDRESS <u>Sodisburg Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF

CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of death	
Place of birth		Place of death		Cause of death		Manner of death	
Occupation		Education		Religion		Marital status	
Previous illness		Medical history		Treatment		Prognosis	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness	
Date of registration		Place of registration		County		State	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin - Rural all life</u>		c. LENGTH OF STAY IN 1b <u>X Rural - Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D.-3</u>		d. STREET ADDRESS <u>R 2nd 3</u>	
3. NAME OF DECEASED (Type or print) <u>Annitta Doretha Griffin</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18, 1959</u>
9. AGE (In years last birthday) <u>4</u> yrs. <u>7</u> months <u>2</u> days		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Ed Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Mary Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>SA 111-111-111</u>	
17. INFORMANT <u>Sallie Miller, Berlin, MD, R+3</u>		Address <u>Berlin, MD, R+3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia (probably)</u> <u>493X</u> DUE TO <u>Cold + lung infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cold + lung infection</u> DUE TO (c) <u>Cold + lung infection</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>overcrowded house (13 in 3 small rooms) poor sanitation</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW BETHEI CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>ART FUNERAL HOME, SALISBURY, MD</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 '59</u>		DATE <u>1/10/59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. K. K. K.</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

01333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Pocomoke City				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #2				d. STREET ADDRESS R.F.D. #2			
3. NAME OF DECEASED (Type or print) First HATTIE Middle B. Last HOWARD				4. DATE OF DEATH Month January Day 15 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Miller				14. MOTHER'S MAIDEN NAME Mary Etta Gibbons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-32-9413		17. INFORMANT W. T. Howard Sr., Pocomoke City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, and DUE TO (c) Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 1, 1958 , to Jan. 15, 1959 , that I last saw the deceased alive on Jan. 15, 1959 , and that death occurred at 4:55 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles W. Trader				ADDRESS (Street, city or town, state) 302 Market St. Pocomoke City, Md.			
DATE SIGNED 1-16-59							
PHYSICIAN'S NAME (Type) Charles W. Trader							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE JAN 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Journal of Management Education 30(6)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

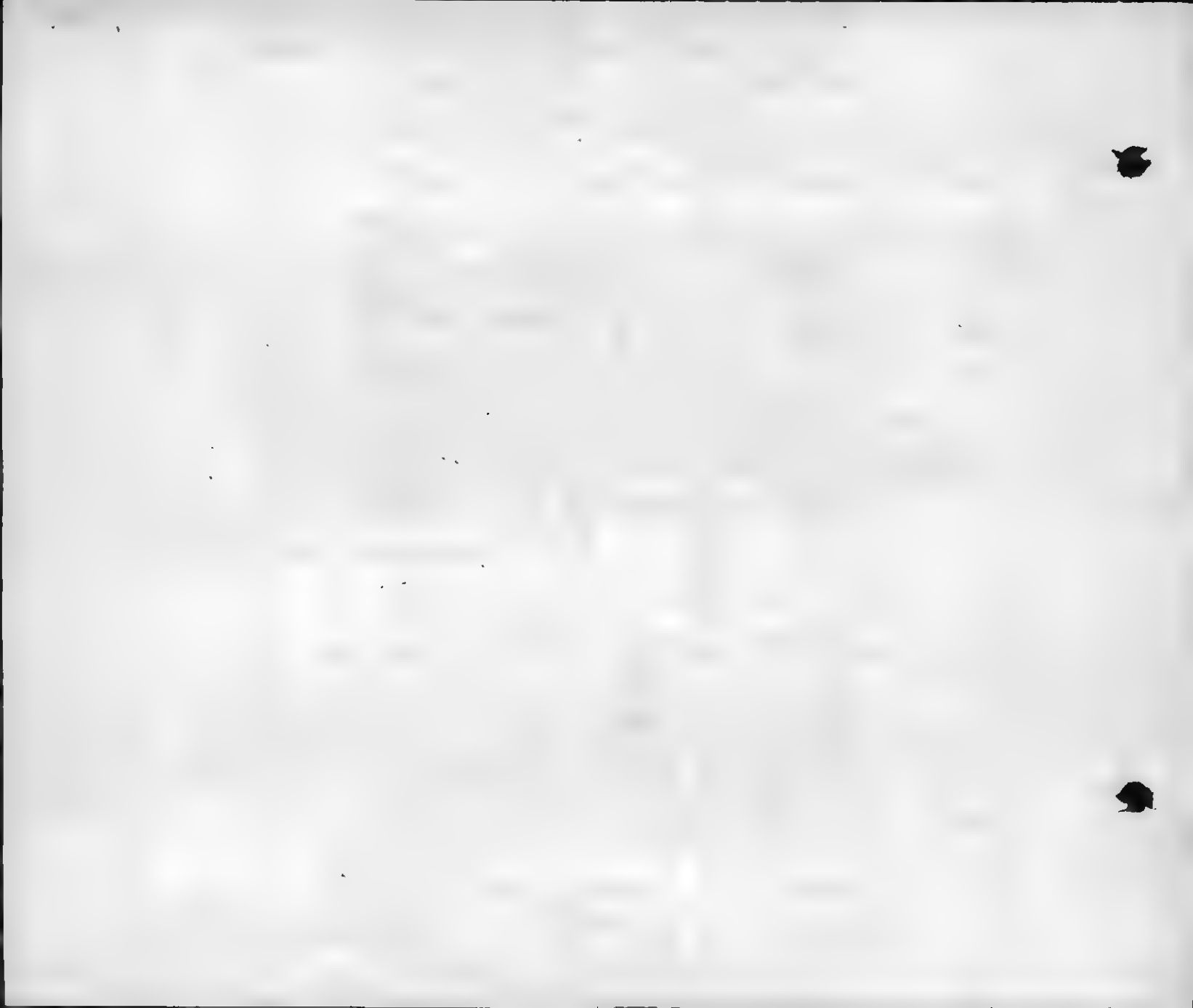
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin - Rural White Mt</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - 1 Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>R.F.D. No 2</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Johnson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23rd 1905</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Tom Tangle</u>	
14. MOTHER'S MAIDEN NAME <u>Ella Pitts</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>204-24-9552</u>		17. INFORMANT <u>Bertha Smith</u> Address <u>Berlin Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident, probably</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Chronic Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emmerson Ave</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. S. McLean</u>		24a. REC'D BY REGISTRAR <u>Jan 29 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

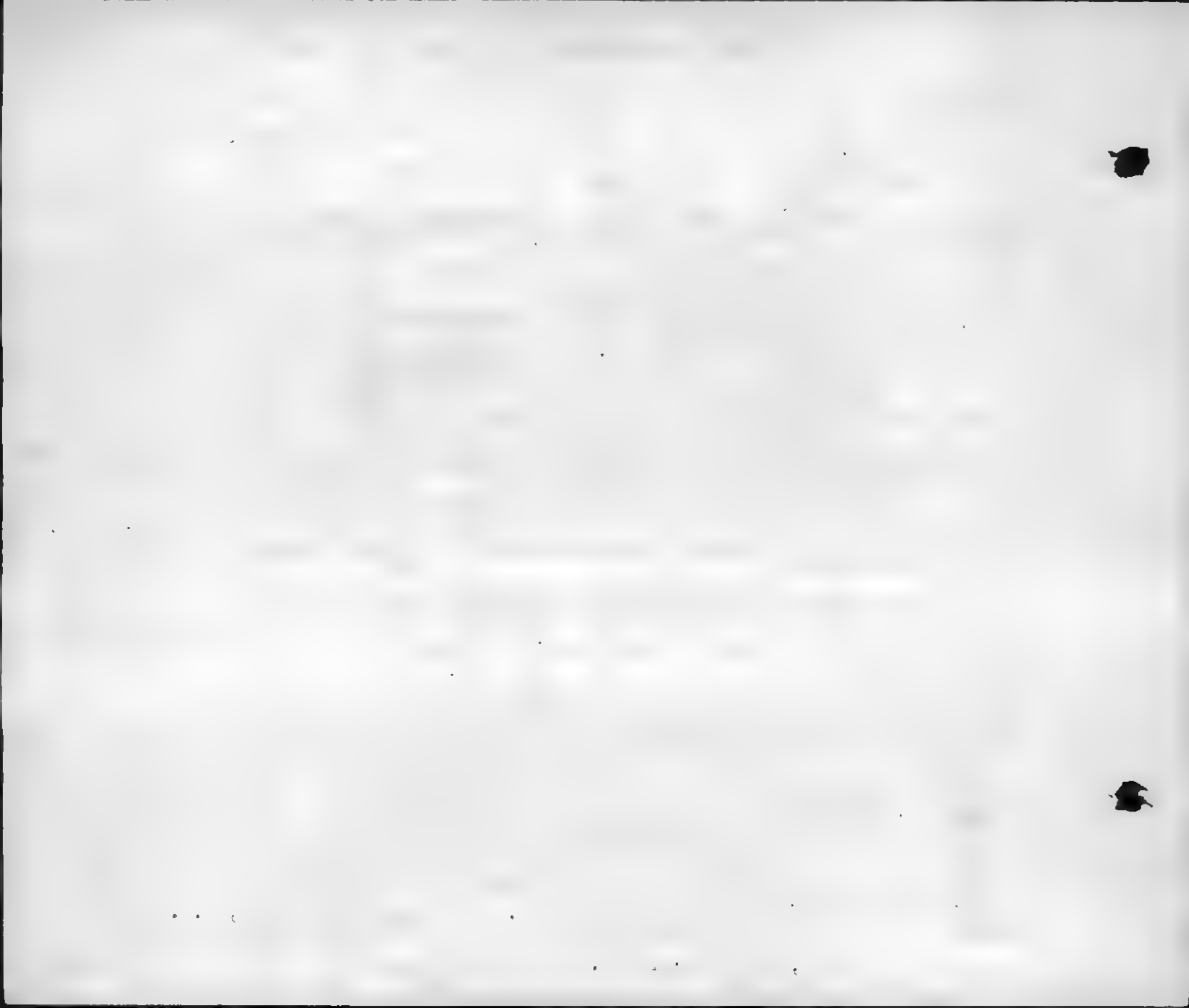
01335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		d. STREET ADDRESS <u>713-4th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Henry</u> Middle <u>Mandel</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1905</u>
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	
11. BIRTH PLACE (State or foreign country) <u>Beaver Dam, VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lennie Tull</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Pannell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-34-981</u>	
17. INFORMANT <u>Nellie Mandel</u> Address <u>Pocomoke City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic changes of lung</u> DUE TO <u>(Probably) tuberculosis of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to</u> (c) <u>Free-kidney</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hunting Trip day before death</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius Sr</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. SARTORIUS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01336

1337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> c. LENGTH OF STAY IN 1b <u>from 11/25/54 to death</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill - Rural</u> d. STREET ADDRESS <u>Daves St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Loa</u> First <u>Teresa</u> Middle <u>Maria</u> Last <u>Martinez</u> 4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1959</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept 18 58</u> 9. AGE (in years last birthday) yrs. <u>42</u> <u>10</u> IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ed Henry Martinez</u>				14. MOTHER'S MAIDEN NAME <u>Lafonda Desobry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Lafonda Desobry</u> Address <u>2501 Rte 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intermittent Pneumonia</u> <u>096.9</u> DUE TO <u>Virus Infection</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>N. E. Sartorius Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1/12/59</u>			
22a. BURIAL CREMATION, REBURYAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) <u>Snow Hill</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Gummis</u>				24a. REC'D BY REGISTRAR <u>Jan 12 1959</u>			
ADDRESS <u>Snow Hill, MD</u>				24b. REGISTRAR'S SIGNATURE _____			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

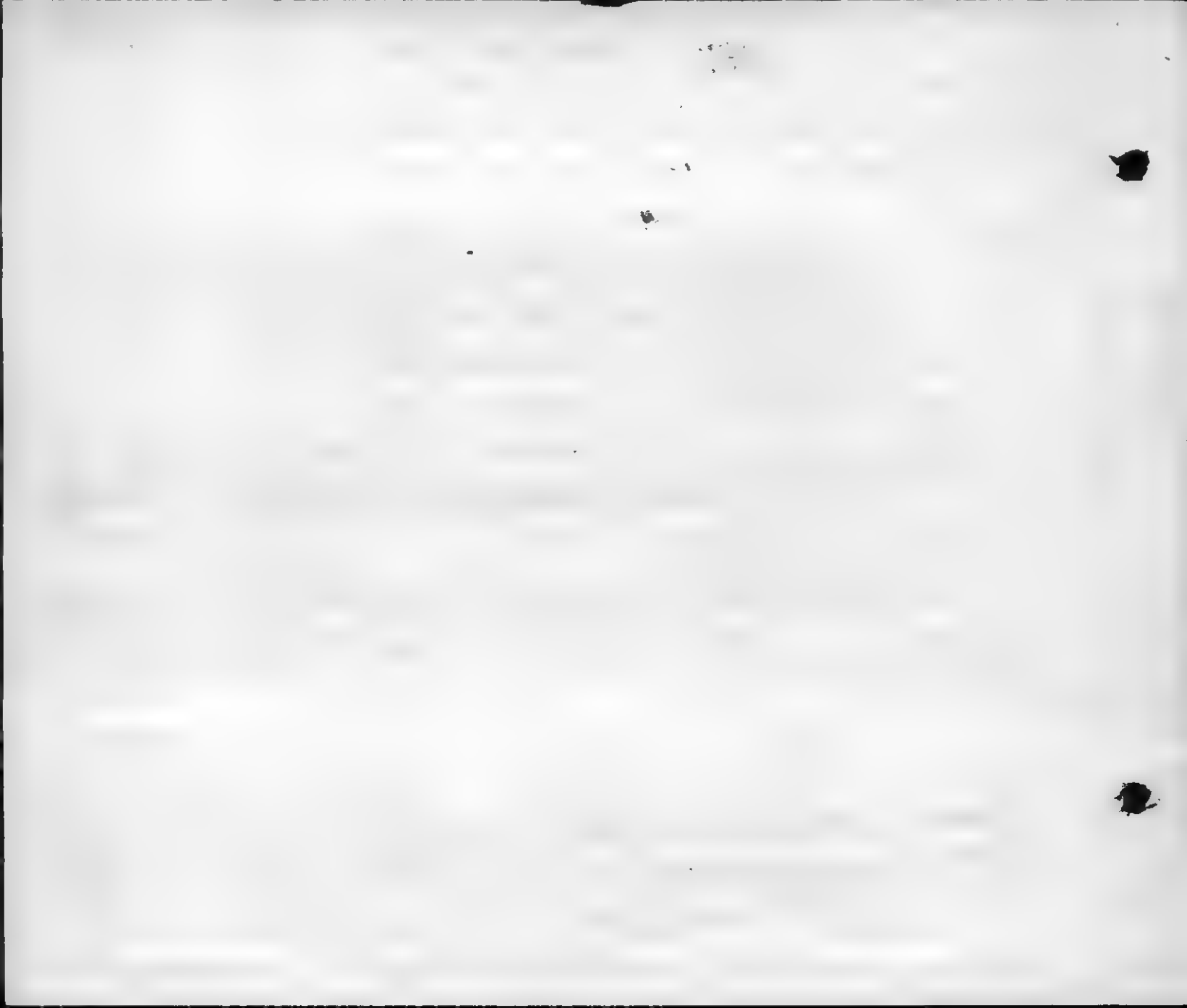
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Filed 1/30/59 et
1335 CERTIFICATE OF DEATH

01337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Staceton</u>	c. LENGTH OF STAY IN 1b <u>88 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Staceton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>B.</u> Last <u>Payton</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 - 1870</u>
9. AGE (In years (b) birthday) <u>88 1/2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Staceton</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>William Bratten</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Philip B. Payton</u>		Address <u>Staceton, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident.</u> 14 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>10 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-1-58</u> , 19 <u>58</u> , to <u>1-30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-29-59</u> , 19 <u>59</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		ADDRESS (Street, city or town, state) <u>104 BAY ST SNOW HILL, Md.</u>	
DATE SIGNED <u>1/30/59</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb 1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Staceton, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Gibbs</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 2 59</u>		24b. REGISTRAR'S SIGNATURE <u>i. e. d. d.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
c. LENGTH OF STAY IN b <u>67 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Smach</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Grotonshire, md</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>M. Laurence Smach</u>		Address <u>Snow Hill md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VAS CULAR ACCIDENT</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>10 YRS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-1-54</u> , 19____, to <u>1-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-20-59</u> , 19____, and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Lamar</u> M.D. <u>1045194 ST</u>		ADDRESS (Street, city or town, state) <u>SNOW HILL, md</u> DATE SIGNED <u>1/21/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. LAMAR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Harris</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>Walter E. Harris</u>	24b. REGISTRAR'S SIGNATURE <u>Walter E. Harris</u>

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1340

CERTIFICATE OF DEATH

01339

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. LENGTH OF STAY IN 16 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MURRAY Last TIMMONS		4. DATE OF DEATH Month January Day 7 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Timmons		14. MOTHER'S MAIDEN NAME Amelia Aydelotte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-34-6011	
17. INFORMANT Mrs Bessie E. Timmons, Stockton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive CardioRenal Disease DUE TO (c) with cerebral accident		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 50 , 19 50 , to 19 59 , 19 59 , that I last saw the deceased alive on Jan 6 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul Cohen M.D. Snow Hill Md Jan 9, 19 59			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-59	
22c. NAME OF CEMETERY Porterville Methodist		22d. LOCATION (City, town, or county) (State) Stockton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson		24a. REC'D BY REGISTRAR ADDRESS Pocomoke City, Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		DATE JAN 12 '59	

CERTIFICATE OF DEATH

1931

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1886	
Place of Birth		Occupation		Cause of Death		Date of Death	
New York City		Teacher		Heart Disease		Jan 20, 1931	
Place of Death		Physician		Burial Place		Burial Date	
New York City		Dr. Smith		Cemetery		Jan 22, 1931	
Signature of Physician		Signature of Registrar		Signature of Family		Signature of Minister	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	